PRINTED: 08/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIOER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETEO IDENTIFICATION NUMBER: A. BUILOING AND PLAN OF CORRECTION R-C B. WING 08/03/2016 495362 STREET AOORESS, CITY, STATE, ZIP COOE NAME OF PROVIDER OR SUPPLIER 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 PROVIDER'S PLAN OF CORRECTION IX5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) IO (EACH CORRECTIVE ACTION SHOULO BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX OATE PREFIX CROSS-REFERENCEO TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) T4G TAG OEFICIENCY) Preparation and submission {F 000} (F 000) INITIAL COMMENTS of this plan of correction does not constitute an An unannounced Medicare/Medicaid third revisit admission or agreement by survey to the abbreviated survey ending 3/31/16 the provider of the truth of and first revisit survey ending 5/12/16 and the second revisit ending 6/30/16, was conducted on the facts alleged or the 8/2/16 through 8/3/16. Corrections are required correctness of the for compliance with the following 42 CFR Part conclusions set forth on the 483 Federal Long Term Care Requirements. statement of deficiencies. Uncorrected deficiencies are identified within this The plan of correction is report. Corrected deficiencies are identified on prepared and submitted the CMS 2567-B. Two complaints were investigated during this survey. solely because of the requirements under State The census in this 190 certified bed facility was and Federal Law. This Plan 167 at the time of the survey. The survey sample of Correction serves as consisted of 16 current record reviews (Resident the Facility's allegation of #301 through #316). F 157 483.10(b)(11) NOTIFY OF CHANGES F 157 substantial compliance. SS=D (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician F157 intervention, a significant change in the resident's 1. The Physician has been physical, mental, or psychosocial status (i.e., a notified that resident #311 deterioration in health, mental, or psychosocial status in either life threatening conditions or did not receive medications clinical complications); a need to after treatment as ordered. The Physician significantly (i.e., a need to discontinue an

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE dministrator

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) OATE

§483.12(a).

existing form of treatment due to adverse

the resident from the facility as specified in

consequences, or to commence a new form of treatment); or a decision to transfer or discharge has been notified of resident

#312 refusal of medication.

No adverse reactions were

variance.

noted due to the medication

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OFNEDS	EOD MEDICARE	R MEDICAID SERVICES			OMR NO	<u>. 0930-039</u>
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			ESURVEY APLETED
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The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, and facility document review it was determined that the facility staff failed to notify the physician for changes in the medication condition for two of 16 residents in the survey sample, Residents #311 and #312.

- 1. The facility staff failed to notify the physician when medications were not administered per the physician order for Resident # 311.
- 2. The facility staff failed to notify the physician when Resident # 312 refused his medications.

The findings include:

1. Resident # 311 was admitted to the facility on 9/27/13 with a readmission on 11/20/13 with diagnoses that included but not limited to: diabetes mellitus (1), hypertension (2), cerebral vascular accident (3), low iron and sacral fracture (4).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment

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- 2. Residents that reside in this facility have the potential to be affected by this deficient practice. The physician has been notified for residents who did not receive medications as ordered. There have been no adverse effects to residents identified.
- 3. Licensed Nursing staff has been educated on following Physician orders for medication administration, notifying the Physician for medication refusal and any significant changes. Licensed Nursing staff has also completed a medication administration course. MARs/TARs will be audited daily x3 months then weekly x 3months by DCS/designee to ensure that medications are being administered as per Physician orders and any refusals have been reported to the Physician.

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STATEMENT	OF	DEFICIENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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495362

B. WING

08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
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F 157 Continued From page 2

reference date) of 5/25/16 coded Resident # 311 coded the resident as scoring a 10 (ten) on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 (ten) being moderately impaired of cognition. Resident # 311 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 311 documented:

- "Humalog (5). Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner Hold of blood sugar < (less than) 140. 9a.m. Start 12/26/15."
- · "Lantus (6). Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR (medication administration record) dated July 1016 for Resident # 311 documented:

- "Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner Hold of blood sugar < (less than) 140. Start 12/26/15."
- **TLantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16." The MAR evidenced missing documentation for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the

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4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.
5. 8-22-16

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STREET ADDRESS, CITY, STATE, ZIP CODE

906 THOMPSON STREET ASHLAND, VA 23005

ASHLAND NURSING AND REHABILITATION

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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DEFICIENCY)

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The MAR (medication administration record) dated August 2016 for Resident # 311 documented:

"Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR evidenced missing documentation for the administration of Lantus on: 8/1/16 at 9:00 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the physician.

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN (licensed practical nurse) # 12, charge nurse. LPN # 12 was asked to review the July and August MARs for Resident # 311. After reviewing the MARs LPN #12 was asked about the missing documentation on the MARs for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. LPN # 12 stated, "If it not documented it wasn't done/administered." When asked if the physician should have been notified that Resident # 311's insulin was not administered LPN # 12 stated, "The physician should have been notified." When asked about the process of checking the MAR for missing documentation LPN # 12 stated, "The MAR is checked by administration and/or the charge nurse every day for holes and accuracy. The eleven to seven or seven to three shift should have picked up the missing documentation and notified the physician. When asked who was to

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	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
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F 157 Continued From page 4 administer Resident # 311's Lantus on 8/1/16 at 9:00 p.m. LPN # 12 stated, "(LPN # 13)."

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN # 13 regarding the missing documentation on the August MAR for Resident # 311. When asked if she was the nurse for Resident # 311 on 8/1/16 during the 3:00 p.m. to 11:00 p.m. shift LPN # 13 stated, "Yes." LPN # 13 was then asked to review the August MAR for Resident # 311 and was asked if Lantus was administered to Resident # 311 at 9:00 p.m. on 8/1/16. LPN # 13 stated, "No, I don't think I gave it. I didn't know it until you pointed it out." When asked about notifying the physician that Resident # 311 didn't receive the Lantus LPN # 13 stated, "Should have notified the physician."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. "Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient."

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

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	regulate the amou	ase in which the body cannot int of sugar in the blood) This btained from the website: nih.gov/medlineplus/ency/articl	le		

(3) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm.

/001214.htm>.

- (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.
- (4) Located at the base of your spine. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000610.htm.
- (5) Humalog (lispro) insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: httml>.
- (6) Lantus (glargine) insulin is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website:

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R-C 08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET ASHLAND, VA 23005

STREET ADDRESS, CITY, STATE, ZIP CDDE

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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https://medlineplus.gov/druginfo/meds/a600027.h

2. Resident # 312 was admitted to the facility on 1/15/16 with a readmission on 5/16/16 with diagnoses that included but not limited to: glaucoma (1), skin cancer, coronary artery disease (2), Parkinson's disease (3), hyperlipidemia (4), pain, enlarged prostate (5), and hypothyroidism (6).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/16 coded Resident # 312 coded the resident as scoring a 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition. Resident # 312 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 312 documented:

- "Allopurinol (7). 100MG (milligrams). Take two every day. 9a.m. (9:00 a.m.). Start 05/17/16."
- "Clopidogrel Bisulfate (8). 75MG. Take one tab (tablet) every day. 9a.m. Start 05/17/16."
- "Finasteride (9). 5MG. Take 1(one) tab every day. 9a.m. Start 05/17/16."
- "Tamsulosin (10). 0.4MG. Take 1 (one) cap (caplet) by mouth every day. 9a.m. Start 05/17/16."
- "Vitamin B-12 (11). 500MCG (microgram). Take 1(one) tab by mouth every day. 9a.m. Start 05/17/16."
- "Calcium Carbonate. (12). 600MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. (5:00 p.m.) Start 05/17/16."
 - "Furnsemide (13). 20MG. Take 1(one) tab

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906 THOMPSON STREET

ASHLAND, VA 23005

ASHLAND NURSING AND REHABILITATION

SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)

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by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."

- "Senexon (14). 8.6MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- "Carbidopa-Levodopa (15). 25MG-100MG. Take 3(three) tab by mouth three a day. 9a.m., 5p.m., 9p.m. (9:00 p.m.). Start 05/17/16."
- "Atorvastatin (16). 10MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."
- "Quetiapine Fumarate (17). 25MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."

The MAR dated July 2016 for Resident # 312 documented:

- "Allopurinol (7). 100MG (milligrams). Take two every day. 9a.m. (9:00 a.m.). Start 05/17/16."
- "Clopidogrel Bisulfate (8). 75MG. Take one tab (tablet) every day. 9a.m. Start 05/17/16."
- "Finasteride (9). 5MG. Take 1(one) tab every day. 9a.m. Start 05/17/16."
- "Tamsulosin (10). 0.4MG. Take 1 (one) cap (caplet) by mouth every day. 9a.m. Start 05/17/16."
- "Vitamin B-12 (11). 500MCG (microgram). Take 1(one) tab by mouth every day. 9a.m. Start 05/17/16."
- "Calcium Carbonate. (12). 600MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. (5:00 p.m.) Start 05/17/16."
- "Furosemide (13). 20MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- "Senexon (14). 8.6MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- · "Carbidopa-Levodopa (15). 25MG-100MG. Take 3(three) tab by mouth three a day. 9a.m.,

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B. WING

R-C 08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET ASHLAND, VA 23005

STREET AOORESS, CITY, STATE, ZIP COOE

(X4) ID PREFIX TAG SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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05/17/16."

5p.m., 9p.m. (9:00 p.m.). Start 05/17/16."

"Atorvastatin (16). 10MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."

" Quetiapine Fumarate (17). 25MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start

The July 2016 MAR for Resident # 312 evidenced the nurse's initials circled for the administration of:

- Allopurinol on 7/28/16 at 9a.m.
- Clopidogrel Bisulfate on 7/28/16 at 9a.m.
- Finasteride on 7/28/16 at 9a.m.
- Tamsulosin on 7/28/16 at 9a.m.
- Vitamin B-12 on 7/28/16 at 9a.m.
- Calcium Carbonate on 7/28/16 at 9a.m. and 5p.m.; 7/31/16 at 5p.m.
- Furosemide on 7/28/16 at 9a.m. and 5p.m.; 7/31/16 at 5p.m.
- Senexon on 7/28/16 at 9a.m. and 5p.m.; 7/31/16 at 5p.m.
- Carbidopa-Levodopa on 7/28/16 at 9a.m. and 9p.m.; 7/29/16 and 7/31/16 at 9p.m.;
- 7/31/16 at 5p.m.

 Atorvastatin on 7/31/16 at 9p.m.
- Quetiapine Fumarate on 7/31/16 at 9p.m. Further review of the MAR failed to evidence documentation on the back of the MAR that the physician was notified of Resident # 312's refusal of medications. The review of the nurse's notes did not reveal any notification to the physician.

On 8/3/16 at 9:45 a.m. an interview was conducted with RN (registered nurse) # 1, unit manager. When asked about nurse's initials being circled on the MAR RN # 1 stated, "It means the person refused the meds (medication), they were held or the person wasn't in the building. The reason is documented on the

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DEPARTMENT OF H	EALTH AND HOMAN CERVICI	FS	OMB NO. 0938-039
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back of the MAR. The physician is notified and it is documented in the nurse's notes." RN # 1 was then asked to review the MAR dated June 2016 and nurse 's notes dated 71/16 through 7/31/16 for Resident # 312. RN # 1 acknowledged Resident # 312 refused the medications on 7/28/16, 7/29/16 and 7/31/16. RN #1 further stated that there was no documentation that the physician was notified of Resident #312's refusal of medications.

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:

- (1) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.ht
- (2) A common type of heart disease. This information was obtained from the website: https://www.nim.nih.gov/medlineplus/coronaryart erydisease.html>.
- (3) Type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsons disease.html>.

(4) High cholesterol. This information was

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Facility IO: VAD008

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DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			(RINTED: 08/16/2016 FORM APPROVED VIB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	C,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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	(5) Enlarged prost hyperplasia) the p helps make seme The prostate surro out of the body. T from the website:	ate (benign prostatic rostate is a gland in men. It n, the fluid that contains spermounds the tube that carries urin his information was obtained lus.gov/enlargedprostatebph.ht	ı. ie				
	(6) Not enough th body's needs. Th	yroid hormone to meet your iis information was obtained					

(7) Used to treat gout. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682673. html>.

https://www.nlm.nih.gov/medlineplus/hypothyroidi

(8) Used to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain. This information was obtained from the website: httml>.

- (9) Used to treat benign prostatic hypertrophy (BPH; enlargement of the prostate gland). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698016. html>.
- (10) Used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or

Facility ID: VA0008

If continuation sheet Page 11 of 5B



from the website:

sm.html.

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STATEMENT	OF DEFICIENCIES
AND PLAN O	F CORRECTION

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

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08/03/2016

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B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

906 THOMPSON STREET

ASHLAND, VA 23005

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 157 Continued From page 11

ASHLAND NURSING AND REHABILITATION

BPH) This information was obtained from the website:

https://mediineplus.gov/druginfo/meds/a698012.

- (11) Helps in the formation of red blood cells and in the maintenance of the central nervous system. This information was obtained from the website: https://medlineplus.gov/ency/article/002403.htm >.
- (12) A dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart. This information was obtained from the website: httml>.
- (13) Used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease This information was obtained from the website:

https://mediinepius.gov/druginfo/meds/a682858.

- (14) Senexon (Senna) used on a short-term basis to treat constipation This information was obtained from the website: httml>.
- (15) Used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms This information was obtained from the website: httmi>.

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Facility ID: VA0008

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING _ ND PLAN OF CORRECTION R-C 08/03/2016 B. WING 495362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 906 THOMPSON STREET

ASHLAND NURSING AND REHABILITATION

ASHLAND, VA 23005

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 157 Continued From page 12

(16) Used to decrease the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol ('bad cholesterol') and triglycerides in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol ('good cholesterol') in the blood. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600045. html>?

(17) Used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.h

{F 281} 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

> The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow professional standards of practice for one of 16 residents in the survey sample; Resident #314.

F 157

{F 281}

F281 The order for blood pressure checks for resident #314 has been discontinued as per Physicians original order.

2. Residents that reside in this facility have the potential to be affected by this deficient practice. A review of Physician orders for the last thirty days has

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> R-C 08/03/2016

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B. WING

STREET AODRESS, CITY, STATE, ZIP COOE

905 THOMPSON STREET

ASHLAND, VA 23005

ASHLAND NURSING AND REHABILITATION (X4) IO PRÉFIX

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SUMMARY STATEMENT OF OFFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)

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(F 281) Continued₂From page 13

The facility staff transcribed an order that had already been discontinued on 7/26/16, onto the August 2016 POS (Physician Order Sheet) and onto the August 2016 MAR (Medication Administration Record) for Resident #314.

The findings include:

Resident #314 was admitted to the facility on 4/17/15 with diagnoses that included but were not limited to osteoarthritis, diabetes mellitus type 2, chronic pain syndrome, high blood pressure, Alzheimer's disease, and unspecified dementia. Resident #314's most recent Minimum Data Set (MDS) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/1/16. Resident #314 was coded as being severely impaired in cognition, scoring three out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #314 was coded as requiring supervision with most ADLS (Activities of Daily Living) and extensive assistance with bathing. Review of Resident #314's physician orders revealed the following order dated 7/19/16: "Check BP (Blood Pressure) daily x (times) one week. Call if SBP (Systolic Blood Pressure) is greater than 150." This order was initiated on 7/19/16 and stopped a week later per physician order, on 7/26/16. Review of the August 2016 POS (Physician Order

Sheet), not yet signed by the physician, but signed by a nurse on the unit, revealed a hand written order that documented the following: "Check BP (Blood Pressure) Daily Call MD (Medical Doctor) if SBP greater than 150." This order was supposed to be discontinued on 7/26/16, and was put back on the August POS (Physician Order Sheet). Review of the August 2016 MAR (Medication

Administration Record) revealed the following order: "7/19/16, Check BP q shift, Notify the MD

not revealed any additional transcription errors.

- 3. Licensed Nursing staff has been educated on proper transcription of Physician orders. DCS/designee will validate proper transcription of Physician orders by checking the MARs/TARs daily x3 months then weekly x 3 months.
- 4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and quarterly thereafter. The committee will recommend provisions to the plan as indicated to sustain substantial compliance 5.8-22-16

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(X3) OATE SURVEY COMPLETED

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B. WING

08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET ASHLAND, VA 23005

STREET ADORESS, CITY, STATE, ZIP CODE

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{F 281} Continued From page 14

of SBP greater than 150." Review of the MAR revealed that Resident #314's blood pressure was checked on 8/1/16 3-11 shift and 8/2/16 on 11-7 shift.

On 8/3/16 at 11:16 a.m., an interview was conducted with RN (Registered Nurse) # 1, the unit manager. When asked how long Resident #314's blood pressure was supposed to be monitored, RN #1 stated, "Should have been for one week." RN #1 stated it was a transcription error and the order for the blood pressure should not have been placed on the August 2016 POS or MAR. When asked who was responsible for transcribing orders, RN #1 stated, "The nurses or unit managers. The nurse who transcribed this is not working today."

On 8/3/16 at 11:30 a.m., an interview was attempted with the nurse who transcribed the order. She could not be reached for an interview. On 8/3/16 at 11:35 a.m., an interview was conducted with ASM (Administrative Staff Member) # 4, the Regional Director of Clinical Services. ASM #4 stated that it looked like a transcription issue.

On 8/3/16 at 12:05 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #11. When asked who was responsible for transcribing orders, LPN # 11 stated that usually the unit managers will do it but sometimes nurses will transcribe. When asked the process of transcribing orders, LPN #11 stated that nurses would look at the physician orders and the previous POS and then transcribe active orders to the new POS and new MAR. LPN #11 stated that 11-7 shift nurses also check the MARS and TARS (Treatment Administration Record) during the month change over for errors. On 8/3/16 at 2:35 p.m., ASM #1, the Executive

Director, ASM #2, the Director of Clinical

{F 281}

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Clinical Services, a Director of Clinical the above findings The facility policy not address transo month. No further informa According to "Fun edition, 2009, Pat Perry: Mosby, Inc health care provio nurse is responsil written orders. If during an emerge by the physician of as possible, usua as possible, usua as possible, usua as possible, usua F 282} FERSONS/PER The services pro must be provided accordance with care. This REQUIREM by: Based on staff i review, and clinic determined that services in acco care for three of sample; Reside	the Assistant Director of and ASM #4, the Regional Services were made aware of it. Ititled, "Physician Orders," did cribing orders from month to ation was presented prior to exit damentals of Nursing" 7th ricia A. Potter and Anne Griffin; Page 336, "The physician or der should write all orders. The ble for transcribing correctly a verbal order is necessary (e.gency), have it written and signed or health care provider as soon ally within 24 hours."	3. 1 {F	282}	F282 1. Resident #316 in his abdominal bin ordered by Physic resident #310 the guard is in place at checked every shit Physician order. Resident as properties and found to be inders and found to be indered.	der as cian. For wander- and being ift as per Resident diabetic ber have inal guards, and cotential to ervations eted for dominal der-guards

DEPARTMENT OF HEALTH AND HUMAN SERVICES NOADE & MEDICAID SERVICES

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906 THOMPSON STREET ASHLAND; VA 23005

ASHLAND NURSING AND REHABILITATION

SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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{F 282}

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)

(X5)COMPLETION DATE

(F 282) Continued: From page 16

2. The facility staff failed to follow the plan of care for the implementation of Resident # 310's wander guard.

3. The facility staff failed to follow Resident # 311's care plan for the administration of insulin, Humalog and Lantus.

The findings include:

1a. Resident # 316 was admitted to the facility on 6/8/16 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), muscle weakness, heart failure, high blood pressure and chronic respiratory failure. Resident #316's most recent MDS (Minimum Data Set) was a five day scheduled assessment with an ARD (Assessment Reference Date) of 7/29/16. Resident #316's was coded as being severely cognitively impaired in the ability to make daily decisions scoring three on the staff assessment for mental status exam. Resident #316 was coded as requiring extensive assistance to being dependent on staff with ADLS (Activities of Daily Living). The resident was coded as having a peg tube. On 8/2/16 at 2:40 a.m., observation of Resident #316 was conducted. Two nursing aides, CNA (certified nursing assistant) #3 and CNA # 4 were in the room and had just finished changing him. When asked if the resident had a peg tube, CNA #3 and CNA #4 stated yes. When asked if Resident #316 had his abdominal binder in place, CNA #4 stated, "I am not sure let me check." She lifted up the Resident's shirt, just to expose his stomach and he did not have his abdominal binder in place. On 8/2/16 at 3:00 p.m., CNA #4 stated, "Apparently his abdominal binder has been in the laundry to be washed." CNA #4 could not

compliance. Medication observations are being conducted by the DCS/designee for currently employed licensed nurses. 3. Licensed Nursing staff has been educated on following Physician orders for medication administration, following treatment orders, and accurate and complete documentation. Licensed Nursing staff has also completed a medication administration course. MARs/TARs will be audited daily x3 months then weekly x 3 months by DCS/designee to ensure that medications are being administered as per Physician order and treatments have been executed as per Physician order, to include abdominal binders, wander-guards and insulin.

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Event IO: J2WF14

Facility IO: VA0008

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ASHLAND NURSING AND REHABILITATION

ASHLAND, VA 23005

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

{F 282} Continued From page 17

remember when it was brought to the laundry or how long the resident did not have his abdominal

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

A physician order documented, "Abdominal Binder check placement and skin qs (every shift) and prn (as needed)...'

Review of Resident #316's care plan dated 6/22/16 documented the following intervention under care area ADLS (Activities of Daily Living) that was initiated on 7/22/16: "Abdominal Binder as ordered."

Review of the July 2016 MAR revealed that on July 30th and 31st 2016, the MAR was left blank for 7-3, 3-11 and 11-7 shift for the Abdominal binder order. Further Review of Resident #316's August 2016 TAR (treatment administration record) revealed that the order for the Abdominal binder had not been documented as administered at that time.

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN #2, regarding the process followed when a resident has an order for an abdominal binder to be put into place but it needs to be washed. LPN #2 stated that something would have to be put into place while the abdominal binder was being washed. LPN #2 stated the resident should either have a second abdominal binder or he would ask the treatment nurse to put something in place to protect the resident's peg tube. LPN #2 stated that if there is an order for an abdominal binder and it is on the care plan than it should have been on. He stated he wasn't sure how long it usually took laundry to bring items like an abdominal binder back to the unit. When asked what was the purpose of the care plan, LPN #2 stated that it was a guideline on what is going on with the patient, what needs to be put into place and what is expected as an

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4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.

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{F 282} Continued From page 18 outcome. LPN #2 stated that all nurses and CNA's have access to the care plan.

On 8/3/16 at 10:35 a.m., an interview was conducted with LPN #4. She stated that she worked 11-7 shift on 8/1/16 to 8/2/16 and that the abdominal binder was in place. When asked what process is followed when a resident's abdominal binder needs to be washed, LPN #4 stated the resident should have two in case the one needs to be changed out. LPN #4 stated that if there is an order for an Abdominal Binder and it is on the care plan it should have been in place.

On 8/3/16 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7, the nurse who worked the weekend on July 30th through the 31st 2016. When asked what blanks meant on the MAR she stated the nurse may have forgotten to sign the MAR or the treatment or medication was not administered. LPN #7 stated that she had worked on 7/30 and 7/31/16 7-3 and 3-11 shift. When asked if she had Resident #316, LPN #7 stated that she did. When asked if he had his abdominal binder in place, LPN #7 stated that she was not sure about Saturday but she knew on Sunday he did not have one in place. When asked why he did not have his abdominal binder in place, LPN #7 stated, "I didn't think we were putting it on him because he had a peg tube infection." When asked if she had documented anywhere that she did not place the binder on due to an infection, LPN #7 stated that she did not. When asked if there was an order to hold the abdominal binder until the infection healed, LPN #7 stated that she could not remember.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING
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		STREET ADORESS, CITY, STATE, ZIP CODE

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08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET
ASHLAND, VA 23005
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{F 282} Continued From page 19

On 8/3/16 at 11:50 a.m., an interview was conducted with LPN #8. She stated that had worked on August 1st 2016, on 11-7 shift. LPN #8 stated that the abdominal binder was in place during her shift. LPN #8 stated that if the abdominal binder had to be washed that she would refer to her DCS (Director of Clinical Services) or unit manager for directions. LPN #8 stated that she would probably put a towel or sheet to protect the resident's peg tube. LPN #8 stated that if the abdominal binder was on the care plan or there was an order than it should have been in place.

On 8/3/15 at 12:05 p.m., an interview was conducted with LPN #11. When asked what the purpose of the care plan was, LPN #11stated it was to let facility staff know, other than nurses, what is going on with the resident such as what interventions are put into place. When asked if a resident has an intervention on the care plan for an abdominal binder should an abdominal binder be in place, LPN #11 stated, "Yes it should be on the resident."

On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.

The facility policy titled, "Plans of Care" documents in part, the following: "Direct Care Staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary. No further information was presented prior to exit. According to Potter and Perry's, Fundamentals of

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{F 282}	care plan communication other health care plan enhances the specific nursing in the goals of care. blueprint for nursing for implementation	age 20 on, page 269 states "A written nicates nursing care priorities to professionals. The nursing care continuity of care by listing iterventions needed to achieve. The complete care plan is the ng action. It provides direction n of the plan plus the framewor he client's response to nursing	e	282}		
	The facility state care for the imple wander guard.	aff failed to follow the plan of ementation of Resident # 310's				
	11/20/15 with a rediagnoses that in dementia with be schizophrenia (2	vas admitted to the facility on eadmission on 2/3/16 with acluded but not limited to: ehaviors disturbances (1), hypertension (3), cannabis cocaine dependence (5).				
	quarterly assess reference date) coded the reside brief interview for 0 - 15, 4 (four cognition. Residence of the code of the	MDS (minimum data set), a ment with an ARD (assessment of 7/20/16 coded Resident # 31 ent as scoring a 4 (four) on the part of the second seco	U			
	The physician's	"Telephone Order" dated 7/29/ /29/16. Wander guard (check)	16			

FORM CMS-2567(02-99) Previous Versions Obsolete

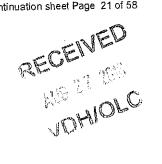
shift"

placement Q (every) shift, 2. Wander guard (check) function 11p-3a (11:00 p.m. to 7:00 a.m.)

EvenI IO: J2WF14

Facility IO: VA0008

If continuation sheet Page 21 of 58



PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION

IX1] PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

495362

R-C 08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

STREET ADDRESS, CITY, STATE, ZIP CODE

IX5I COMPLETION DATE

(F 282) Continued From page 21

The "Behavior / Mood" care plan dated 4/1/2014 for Resident # 310 documented, "Approaches & Interventions: 7/29/16 Wander guard (check) placement QS (every shift); 7/29/16 Wander guard (check) function 11p-7a shift."

Resident # 310's TAR (treatment administration record) dated August 2016 was reviewed. The TAR documented,

"Wander guard (check) placement QS. 7-3 (7:00 a.m.-3:00 p.m.), 3-11 (3:00 p.m.-11:00 p.m.), 11-7 (11:00 p.m.-7:00 a.m.)."

"Check function of wander guard Q day."

The TAR was blank on 8/1/16.

The TAR failed to evidence documentation of the wander guard being checked each shift.

On 8/2/16 at 1:30 p.m. an interview was conducted with LPN (licensed practical nurse) # 12. When asked about blanks on a MAR (medication administration record) and TAR LPN # 12 stated, "If it's not documented it's not done or administered." After reviewing the TAR dated August 2016 for Resident # 310, LPN # 12 was asked about the missing documentation on the TAR for Resident #310's wander guard. LPN # 12 stated, "It was not documented it wasn't done. I check the wander guard in at the beginning of the shift but today I didn't. It should be checked for placement every shift. Being the charge nurse it is something I should have done."

During another interview with LPN # 12 on 8/3/16 at 10:15 a.m. regarding a resident's care plan LPN # 12 stated, "The purpose of the care plan is to let you know the changes or progress of a person. Everything on the care plan should be done." After reviewing Resident # 310's TAR and

{F 282}

PRINTED: 08/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIOER/SUPPLIER/CLIA STATEMENT OF OFFICIENCIES COMPLETEO IOENTIFICATION NUMBER: ANO PLAN OF CORRECTION A. BUILOING R-C 495362 B. WING 08/03/2016 STREET AOORESS, CITY, STATE, ZIP COOE NAME OF PROVIDER OR SUPPLIER 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF OFFICIENCIES Ю (EACH CORRECTIVE ACTION SHOULO BE COMPLETION (X4) IO PREFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PRÉFIX CROSS-REFERENCEO TO THE APPROPRIATE DATE REGULATORY OR LSC IOENTIFYING INFORMATION) TAG TAG OEFICIENCY) {F 282} (F 282) Continued From page 22 care plan RN # 12 was asked if Resident # 310's care plan was followed for checking the wander guard. LPN # 12 stated, "No." The facility's policy "Plans of Care" documented, "Direct care staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his [sic] can be provided and plan of care changed if necessary." Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

aware of the findings.

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and ASM # 3, the regional director of clinical services was made

No further information was obtained prior to exit.

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(F 282) Continued From page 23

{F 282}

- (1) A group of symptoms caused by disorders that affect the brain) This information was obtained from the website:
- https://www.nlm.nih.gov/medlineplus/dementia.h tm!>.
- (2) A mental disorder that makes it hard to tell the difference between what is real and not real.) This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm.
- (3) High blood pressure This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.
- (4) Cannabis dependence (marijuana) is a green, brown, or gray mix of dried, crumbled parts from the marijuana plant. It can be rolled up and smoked like a cigarette or cigar or smoked in a pipe. Sometimes people mix it in food or inhale it using a vaporizer. This information was obtained from the website: https://medlineplus.gov/marijuana.html>.
- (5) A white powder. It can be snorted up the nose or mixed with water and injected with a needle. Cocaine can also be made into small white rocks, called crack. Crack is smoked in a small glass pipe. Some of the most common serious problems include heart attack and stroke. You are also at risk for HIV/AIDS and hepatitis, from sharing needles or having unsafe sex. Cocaine is more dangerous when combined with other drugs or alcohol. This information was obtained from the website: https://medlineplus.gov/cocaine.html.

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{F 282} Continued From page 24

Facility staff failed to follow Resident # 311's care plan for the administration of insulin, Humalog (1) and Lantus (2).

Resident # 311 was admitted to the facility on 9/27/13 with a readmission on 11/20/13 with diagnoses that included but not limited to: diabetes mellitus (3), hypertension (4), cerebral vascular accident (5), low iron and sacral fracture (6).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/25/16 coded Resident # 311 coded the resident as scoring a 10 (ten) on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 (ten) being moderately impaired of cognition. Resident # 311 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 311 documented:

"Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold of blood sugar < (less than) 140. 9a.m. Start 12/26/15."

"Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR (medication administration record) dated July 1016 for Resident # 311 documented:

"Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold of blood sugar < (less than) 140. Start 12/26/15."

"Lantus. Inject 10 (ten) units subcutaneously

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Facility ID: VA0008

Event ID: J2WF14

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(F 282) Continued From page 25

at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16." The MAR evidenced missing documentation for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the physician.

The MAR (medication administration record) dated August 2016 for Resident # 311 documented:

"Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR evidenced missing documentation for the administration of Lantus on: 8/1/16 at 9:00 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the physician.

The "Metabolic" care plan dated 4/1/2014 with a review date of 6/5/16 for Resident # 310 documented, "Focus: The Resident is at risk for Metabolic Complications. Etiologies (the cause): Diabetes." Under "Approaches & Interventions" it documented, "Medications as ordered."

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN #2. When asked what was the purpose of the care plan he stated that it was a guideline on what is going on with the patient, what needs to be put into place and what is expected as an outcome. He stated that all

{F 282}

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(F 282) Continued From page 26

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nurses and CNA's (certified nursing assistants) have access to the care plan.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

During an interview with LPN #12 on 8/3/16 at 10:15 a.m. regarding a resident's care plan LPN# 12 stated, "The purpose of the care plan is to let you know the changes or progress of a person. Everything on the care plan should be done." After reviewing Resident # 31's MAR and care plan LPN # 12 was asked if Resident # 311's care plan was followed for the administration of insulin. LPN #12 stated, "No."

On 8/3/15 at 12:05 p.m., an interview was conducted with LPN #11. When asked what was the purpose of the care plan she stated that it was to let facility staff know, other than nurses, what is going on with the resident such as what interventions are put into place.

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:

(1) Humalog (lispro) insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021. html>.

(2) Lantus (glargine) insulin is also used to treat

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1	acople with type 2	diabetes (condition in which	٠			
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· ·	therefore cannot	control the amount of Sugar in				
1	ila blaad) who ne	sed insulin to control their				
	diabetes. This inf	formation was obtained from the				
1	woheito:					
	https://medlineplu	us.gov/druginfo/meds/a600027.h				
	tml.					
		the body cannot				
1	(3) A chronic dise	ease in which the body cannot				
ļ	regulate the amo	unt of sugar in the blood) This obtained from the website:				
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	https://www.nim	1.Hin.gov/medimeplas/eneg/and	_			
	/001214.htm>.					
ļ	(4) High blood pr	essure. This information was				
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	https://www.nln	n.nih.gov/medlineplus/highbloodp)			
	ressure.html>.					
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}	(5) A stroke. Th	is information was obtained from	ı			
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1		m.nih.gov/medlineplus/ency/artic			F309	
1	/000726.htm>.					
	(6) Located at th	ne base of your spine. This			1. Resident #316	6 is wearing
	information Was	obtained from the Website.			his abdominal bi	-
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\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	HIGHEST WEL	L BEING			Insulin as per Ph	ysician
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	Each resident r	must receive and the facility must	ı in			
1	provide the nec	cessary care and services to atta	11.1			
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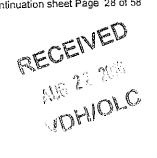
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Event ID: J2WF14

Facility ID: VA0008

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PRINTED: 08/16/2016 FORM APPROVED

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PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

{F 309} Continued From page 28

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This REQUIREMENT is not met as evidenced by:

SLIMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain the highest level of well being for three of 16 residents in the survey sample; Resident #316, #311 and #310.

- 1. Facility staff failed to follow physician orders and ensure an abdominal binder was in place for Resident #316 on 7/31/16 on 7-3 and 3-11 shift and on 8/2/16.
- 2. The facility staff failed to follow Resident # 311's physician's orders for the administration of insulin.
- The facility staff failed to ensure Resident # 310's wander guard was in place as ordered by the physician.

The findings include:

1. Resident # 316 was admitted to the facility on 6/8/16 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), muscle weakness, heart failure, high blood pressure and chronic respiratory failure. Resident #316's most recent MDS (Minimum Data Set) was a five day scheduled assessment with an ARD (Assessment Reference Date) of 7/29/16. Resident #316's was coded as being severely cognitively impaired in the ability to make daily decisions scoring three on the staff assessment for mental status exam. Resident #316 was coded as requiring extensive assistance to being dependent on staff with ADLS

order. For resident #310 the wander-guard is in place and being checked every shift as per Physician order.

- 2. Residents who have orders for abdominal binders, wander-guards, and Insulin have the potential to be affected. Observations have been completed for residents with abdominal binders and wander-guards and found to be in compliance. Medication observations are being conducted by the DCS/designee for currently employed licensed nurses to ensure medication administration.
- 3. Licensed Nursing staff has been educated on following Physician orders for medication administration, following treatment orders and accurate and complete documentation. Licensed Nursing staff has also completed a medication administration course.

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Facility ID: VA0008

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NAME OF PROVIOER OR SUPPLIER

SUMMARY STATEMENT OF OEFICIENCIES

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ASHLAND NURSING AND REHABILITATION

STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET

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(Activities of Daily Living). The resident was coded as having a peg tube.

On 8/2/16 at 2:40 a.m., observation of Resident #316 was conducted. Two nursing aides, CNA (certified nursing assistant) #3 and CNA # 4 were in the room and had just finished changing him. When asked if the resident had a peg tube, CNA #3 and CNA #4 stated yes. When asked if Resident #316 had his abdominal binder in place, CNA #4 stated, "I am not sure let me check." She lifted up the Resident's shirt, just to expose his stomach and he did not have his abdominal binder in place.

On 8/2/16 at 3:00 p.m., CNA #4 stated, "Apparently his abdominal binder has been in the laundry to be washed." CNA #4 could not remember when it was brought to the laundry or how long the resident did not have his abdominal binder.

A physician order documented, "Abdominal Binder check placement and skin qs (every shift) and prn (as needed)..."

Review of Resident #316's care plan dated 6/22/16 documented the following intervention under care area ADLS (Activities of Daily Living) that was initiated on 7/22/16: "Abdominal Binder as ordered."

Review of the July 2016 MAR revealed that on July 30th and 31st 2016, the MAR was left blank for 7-3, 3-11 and 11-7 shift for the Abdominal binder order. Further Review of Resident #316's August 2016 TAR (treatment administration record) revealed that the order for the Abdominal binder had not been documented as administered at that time.

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN #2, regarding the process

MARs/TARs will be audited daily x3 months then weekly x 3 months by DCS/designee to ensure that medications are being administered as per Physician order and treatments have been executed as per Physician order, to include abdominal binders, wander-guards and insulin. Random audits will be conducted for residents with orders for abdominal binders and wander-guards to ensure devices are in place 3x weekly for 1 month. Random medpass observations will be

conducted 3x weekly for 1 month by DCS/designee.

4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and then quarterly. The committee will recommend provisions to the plan as indicated to

compliance 5. 8-22-16

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08/03/2016

NAME OF PROVIOER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET ASHLAND, VA 23005

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{F 309} Continued From page 30

followed when a resident has an order for an abdominal binder to be put into place but it needs to be washed. LPN #2 stated that something would have to be put into place while the abdominal binder was being washed. LPN #2 stated the resident should either have a second abdominal binder or he would ask the treatment nurse to put something in place to protect the resident's peg tube. LPN #2 stated that if there is an order for an abdominal binder and it is on the care plan than it should have been on. He stated he wasn't sure how long it usually took laundry to bring items like an abdominal binder back to the unit.

On 8/3/16 at 10:35 a.m., an interview was conducted with LPN #4. She stated that she worked 11-7 shift on 8/1/16 to 8/2/16 and that the abdominal binder was in place. When asked what process is followed when a resident's abdominal binder needs to be washed, LPN #4 stated the resident should have two in case the one needs to be changed out. LPN #4 stated that if there is an order for an Abdominal Binder and it is on the care plan it should have been in place.

On 8/3/16 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7, the nurse who worked the weekend on July 30th through the 31st 2016. When asked what blanks meant on the MAR she stated the nurse may have forgotten to sign the MAR or the treatment or medication was not administered. LPN #7 stated that she had worked on 7/30 and 7/31/16 7-3 and 3-11 shift. When asked if she had Resident #316, LPN #7 stated that she did. When asked if he had his abdominal binder in place, LPN #7 stated that she was not sure about Saturday but she knew on Sunday he did

{F 309}

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Event IO: J2WF14

Facility IO: VA0008

If continuation sheet Page 31 of 58



PRINTED: 08/16/2016 FORM APPROVED

DEFICIENCY)

		E & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT O	NTERS FOR MEDICARE & MEDICAID SERVICES EMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6) MUL		(X3) OATE SURVEY COMPLETEO		
		495362	B. WING		R-C 08/03/2016
NAIME OF PROVIDER OR SUPPLIER ASHLAND NURSING AND REHABILITATION		STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND, VA 23005			
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(F 309) Continued From page 31

TAG

not have one in place. When asked why he did not have his abdominal binder in place, LPN #7 stated, "I didn't think we were putting it on him because he had a peg tube infection." When asked if she had documented anywhere that she did not place the binder on due to an infection, LPN #7 stated that she did not. When asked if there was an order to hold the abdominal binder until the infection healed, LPN #7 stated that she could not remember.

On 8/3/16 at 11:50 a.m., an interview was conducted with LPN #8. She stated that had worked on August 1st 2016, on 11-7 shift. LPN #8 stated that the abdominal binder was in place during her shift. LPN #8 stated that if the abdominal binder had to be washed that she would refer to her DCS (Director of Clinical Services) or unit manager for directions. LPN #8 stated that she would probably put a towel or sheet to protect the resident's peg tube. LPN #8 stated that if the abdominal binder was on the care plan or there was an order than it should have been in place.

On 8/3/15 at 12:05 p.m., an interview was conducted with LPN #11. When asked if a resident has an order for an abdominal binder should an abdominal binder be in place, LPN #11 stated, "Yes it should be on the resident." The facility policy titled, "Physician orders" did not address the above concern. On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of

Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.

No further information was presented prior to exit.

{F 309}

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CENTERS	FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				0	F	R-C	
		495362	B. WING		08	/03/2016	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
	NURSING AND RE	UARII (TAT(ON		906 THOMPSON STREET			
ASHLAND	NURSING AND NE	HABILITATION		ASHLAND, VA 23005			
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{F 309} Continued From page 32

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In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc. Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

2. The facility staff failed to follow Resident # 311's physician's orders for the administration of

Resident # 311 was admitted to the facility on 9/27/13 with a readmission on 11/20/13 with diagnoses that included but not limited to: diabetes mellitus (1), hypertension (2), cerebral vascular accident (3), low iron and sacral fracture (4).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/25/16 coded Resident # 311 as scoring a 10 out of 15 on the brief interview for mental status (BIMS), indicating the resident was moderately impaired of cognition. Resident #311 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 311 documented: "Humalog (5). Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold if blood sugar < (less than) 140. 9a.m. Start 12/26/15."

{F 309}

Facility ID: VA0008

PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391

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NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	D NURSING AND RE	HABILITATION	!		OMPSON STREET AND, VA 23005		
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{F 309}	Continued From p	age 33	{F 3	309}			
	"Lantus (6). Ir subcutaneously at Start 06/07/16."	nject 10 (ten) units bedtime. 9p.m. (9:00 p.m.)		•			
	dated July 2016 for DM (diabetes)	ation administration record) or Resident # 311 documented: ject 5 (five) units under the skin) three times daily mellitus) at breakfast, lunch and bood sugar < (less than) 140.	,				
	at bedtime. 9p.m The MAR evidence the administration 7/28/16 and 7/29/ 7/28/16 at 7:30 a. 7:30 a.m., 11:30 a review of the MAI documentation of evidencing notific of the physician of	116 at 9:00 p.m. and Humalog of m. and 11:30 a.m.; 7/29/16 at a.m. and 4:30 p.m. Further R revealed that there was no in the reverse side of the MAR cation to the physician. Review tes did not reveal any notification Resident #311's insulin not ed on the dates and times	on				
	dated August 20 documented: "Lantus. In subcutaneously: Start 06/07/16." The MAR evider the administratio	cation administration record) 16 for Resident # 311 sject 10 (ten) units at bedtime. 9p.m. (9:00 p.m.) nced missing documentation for on of Lantus on: m. Further review of the MAR ere was no documentation on the					

reverse side of the MAR for notification to the



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PRINTED: 08/16/2016 FORM APPROVED

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	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 906 THOMPSON STREET ASHLAND, VA 23005	ODE		
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(F 309) Continued From page 34

physician. Review of the nurse's notes did not reveal any notification to the physician of the insulin not being administered as ordered.

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN (licensed practical nurse) # 12, charge nurse. LPN # 12 was asked to review the July and August 2016, MARs for Resident # 311. After reviewing the MARs LPN #12 was asked about the missing documentation on the MARs for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and Lantus pn: 7/28/16 and 7/29/16 at 9:00 p.m. LPN # 12 stated, "If it not documented it wasn't done/administered." When asked if the physician should have been notified that Resident # 311's insulin was not administered, LPN # 12 stated, "The physician should have been notified." When asked about the process of checking the MAR for missing documentation, LPN # 12 stated, "The MAR is checked by administration and/or the charge nurse every day for holes and accuracy. The eleven to seven or seven to three shift should have picked up the missing documentation and notified the physician. When asked who was to administer Resident # 311's Lantus on 8/1/16 at 9:00 p.m., LPN # 12 stated, "(LPN # 13)."

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN # 13 regarding the missing documentation on the August MAR for Resident # 311. When asked if she was the nurse for Resident # 311 on 8/1/16 during the 3:00 p.m. to 11:00 p.m. shift, LPN # 13 stated, "Yes." LPN # 13 was then asked to review the August MAR for Resident # 311 and was asked if Lantus was administered to Resident # 311 at 9:00 p.m. on

{F 309}

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			FORM): 08/16/2016 1APPROVED): 0938-0391
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ANO PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		R-C I
		495362	B. WING			3/03/2016
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ASHLA				ASHLAND, VA 23005	OTION.	****
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{F 309	it. I didn't know it in Basic Nursing, edition (Potter and was a reference s notification. "The provider is respontreatment of a pat On 8/3/16 at 2:20 member) # 1, the the director of clir regional director of aware of the findi	stated, "No, I don't think I gave until you pointed it out." Essential for Practice, 6th depeny, 2007, pages 56-59), ource for physician's orders and physician or health care asible for directing the medical tient." p.m. ASM (administrative staff executive director, ASM # 2, nical services and ASM # 3, the of clinical services was made		09}		

References:

- (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.
- (3) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm.
- (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.
- (4) Located at the base of your spine. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/

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Facility ID: VA0008

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		•	PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO
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{F 309}	Continued From p 000610.htm>.	age 36	{F 3	09}	
	(5) Humalog (lispr	o) insulin is used to treat peop	ole		

- (5) Humalog (lispro) insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.
- (6) Lantus (glargine) insulin is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website:

https://medlineplus.gov/druginfo/meds/a600027.html.

3. The facility staff failed to ensure Resident # 310's wander guard was in place as ordered by the physician.

Resident # 310 was admitted to the facility on 11/20/15 with a readmission on 2/3/16 with diagnoses that included but not limited to: dementia with behaviors disturbances (1), schizophrenia (2), hypertension (3), cannabis dependence (4), and cocaine dependence (5).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/16 coded Resident # 310 as scoring a 4 out of 15 on the brief interview for

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Facility IO: VA0008

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PRINTED: 08/16/2016 FORM APPROVED

DEPARTME	NT OF HEALTH	AND HUMAN SERVICES		0	MB NO. 0938-0391
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		495362	B. WING		08/03/2016
	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
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{F 309} Continued From page 37

mental status (BIMS), indicating the resident was severely impaired of cognition. Resident # 310 was coded as requiring extensive assistance of one staff member for activities of daily living.

A FRI (facility reported incident) dated "07-29-2016" documented, "Resident Involved: (Resident # 310); Injuries: No." Under "Incident Type" it documented, "Resident Elopement." Under "Describe Incident, indicating location, and action taken" it documented, "(Resident # 310) has a diagnosis of muscle weakness, schizophrenia, dementia, with behavioral disturbances, and cognitive communication deficit. (Resident # 310) was let out of the building by staff at approximately 4:03 p.m. (Resident # 310) was seen at the curb by staff and brought back to the facility without any incidence, she was assessed and no injuries were noted. MD/RP (medical doctor/responsible party) were notified."

The nurse's note documented on the "Interdisciplinary Progress Notes" sheet dated 7/29/16 by LPN # 12 at 4:30 p.m. for Resident # 310 documented, "Resident went through the front doors today stating she was headed to (Name of Street). Resident was brought back into building by staff and skin checked over for any new areas in which did no injury occur [sic]. Resident has had a [sic] elopement eval (evaluation) performance and is a risk for elopement. Resident will be having a wander guard placed on her ankle for safety purposes. Resident will be monitored closely for (changes) in status and exit seeking behaviors. MD & (and) RP aware of wander guard being placed on. Message left for RP of info (information)."

{F 309}

PRINTED: 08/16/2016

DEPART	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT	S FOR MEDICARE OF OFFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			INSTRUCTION	(X3) OATE SURVEY COMPLETEO		
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ASILLAN				ASH	LAND, VA 23005 PROVIOER'S PLAN OF CORRECT	MOIT	(X5)	
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{F 309)		age 38 ement Risk Evaluation" dated	{F :	309}				
	2/29/16 for Reside	ent # 310 documented, "Based actors above, resident is AT RISK for elopement: No."						
j	The "Elopement F for Resident # 310 potential risk factor	Risk Evaluation" dated 7/29/16 Odocumented, "Based on bors above, resident is						
	determined to be	AT RISK for elopement: Yes." ephone Order" dated 7/29/16	r					
	documented, "7/2	9 1. Wander guard (check) ery) shift, 2. Wander guard 11p-3a (11:00 p.m. to 7:00 a.m.)						
	for Resident # 31 Interventions: 7/2 placement QS (e	Mood" care plan dated 4/1/2014 0 documented, "Approaches & 9/16 Wander guard (check) very shift); 7/29/16 Wander nction 11p-7a shift."						
	record) dated Aug TAR documented "Wander qua	ard (check) placement QS. 7-3						
	(7:00 a.m3:00 p	o.m.), 3-11 (3:00 p.m11:00 0 p.m7:00 a.m.)." iion of wander guard Q day."						
	The TAR failed to	o evidence documentation of the sing checked each shift.	e					
	conducted with L	0 p.m. an interview was _PN (licensed practical nurse) # ing the TAR dated August 2016						

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for Resident # 310, LPN # 12 was asked about the missing documentation on the TAR for Resident # 310's wander guard. LPN # 12 stated, "It was not documented it wasn't done. I check

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Facility IO: VA0008

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILC	TIPLE CONSTRUCTION
	495362	B. WING	
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(X3) OATE SURVEY COMPLETEO

> R-C 08/03/2016

NAME OF PROVIOER OR SUPPLIER

STREET AUDRESS, CITY, STATE, ZIP C 906 THOMPSON STREET

ASHLAND NURSING AND REHABILITATION

906 THOMPSON STREET ASHLAND, VA 23005

(X4) IO PREFIX TAG SUMMARY STATEMENT OF OFFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IO PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY) JX5J COMPLETION DATE

{F 309} Continued From page 39

the wander guard in at the beginning of the shift but today I didn't. It should be checked for placement every shift. Being the charge nurse it is something I should have done."

On 8/2/16 at 1:40 p.m. an observation was conducted of Resident # 310. Resident # 310 was in her wheelchair, in her room propelling herself around the room. Further observation of Resident # 310 failed to evidence a wander guard on her person or on the wheelchair she was in.

On 8/2/16 at 1:45 p.m. an observation was conducted of Resident # 310 with LPN (licensed practical nurse) # 12, charge nurse. When asked about the wander guard for Resident # 310, LPN # 12 stated it was on Resident # 310's ankle. LPN # 12 was asked to lift the bottom of Resident #310's pants on the right and left legs to observe Resident #310's ankles. Upon lifting the bottom of Resident # 310's pants, LPN # 12 acknowledged the wander guard was not on Resident #310. LPN #12 further examined the wheelchair Resident # 310 was sitting and verified that the wander guard was not attached to the wheelchair either. LPN #12 stated, "She (Resident # 310) had it on yesterday. I'll find out what happened to it."

On 8/2/16 at 2:20 p.m. an interview was conducted with CNA (certified nursing assistant) # 1 in the presence of LPN # 12, charge nurse. CNA # 1 showed this surveyor Resident # 310's wander guard. CNA # 1 stated that while changing Resident # 310 she found the wander guard for Resident # 310 in the dresser drawer. CNA # 1 and LPN # 12 stated Resident # 310 did

{F 309}

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
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{F 309}	stated, "I don't kno examination of the # 12 revealed that	er guard on. LPN # 12 further by how it came off." An wander guard band with LPN the band was still fastened t. LPN # 12 stated, "We'll have	{F 309}		
	Resident # 310 re wheelchair self pr around the nurse' was on Resident;	p.m. an observation of vealed she was in her opelling herself in the hallway s station. The wander guard # 310's wrist and she was watch showing this surveyor and	d		
	member) # 1, the the director of clir	p.m. ASM (administrative staff executive director, ASM # 2, nical services, and ASM # 3, the of clinical services was made ngs.			
	No further inform	ation was obtained prior to exít.			
	References:				
	affect the brain.	mptoms caused by disorders that This information was obtained : nih.gov/medlineplus/dementia.h			
	difference betwe	rder that makes it hard to tell th en what is real and not real. Th obtained from the website: us.gov/ency/artide/000928.htm.	İS		
	(3) High blood p	ressure. This information was			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	1 APPROVED 0. 0938-0391
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{F 309}	abtained from the			309}	F 329		
	(4) Cannabis der green, brown, or parts from the ma and smoked like a pipe. Sometime it using a vaporiz	pendence (marijuana) is a gray mix of dried, crumbled arijuana plant. It can be rolled u a cigarette or cigar or smoked as people mix it in food or inhale er. This information was a website: us.gov/marijuana.html.	ll J		1. Resident provided no pharmacold interventio documenta the effective. 2. Resident	on- ogical ons. There ation to su veness of X ts that resid	is pport (anax.
	or mixed with wa Cocaine can also called crack. Cra pipe. Some of the problems include also at risk for H sharing needles more dangerous	er. It can be snorted up the noster and injected with a needle. It is a made into small white rocking it is smoked in a small glassing most common serious he heart attack and stroke. You ally/AIDS and hepatitis, from or having unsafe sex. Cocained when combined with other druinformation was obtained from os://medlineplus.gov/cocaine.html.	are is		the facility potential to review of re PRN psychomedication conducted pharmacold interventio provided producted administration medication	o be affect residents reotropics as has been to ensure ogical ons have be rior to tron. A rev	eceiving n non- een riew of
{F 32	Each resident's unnecessary drug when used	REGIMEN IS FREE FROM Y DRUGS drug regimen must be free frougs. An unnecessary drug is a in excessive dose (including by); or for excessive duration; of the monitoring or without adequate monitoring or without adequates and the content of the con	m any or	F 329)	also been of also	conducted. ing has been the licens the DCS/de behavior ent program	en sed signee

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indications for its use; or in the presence of

should be reduced or discontinued; or any

adverse consequences which indicate the dose

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If continuation sheet Page 42 of 58

interventions prior to

medication administration,



		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 08/16/2016 FORM APPROVED MB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
•		495362	B. WING_		R-C 08/03/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		, , , , , , , , , , , , , , , , , , , ,		906 THOMPSON STREET	
ASHLANI	NURSING AND RE	HABILITATION		ASHLAND, VA 23005	
(X4) ID PREFIX- TAG	_ /FACH-DÉFICIENC*	ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTID X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DISE COMPLETION
	O- 4		{F 32	201	
{F 329}	Continued From pa		. {i ⊃a	·	
	combinations of th	e reasons above.		documentation prior to	and
	Based on a compr	ehensive assessment of a		after medication	
	resident, the facilit	y must ensure that residents		administration to include	2
	who have not used	d antipsychotic drugs are not		effectiveness. Random	
	given these drugs	unless antipsychotic drug		weekly review will be	
	therapy is necessar	ary to treat a specific condition documented in the clinical		conducted by the	
	ss diagnosed and	nts who use antipsychotic		DCS/designee for five (5)	1
	drugs receive grad	dual dose reductions, and		residents per week for th	ree
	behavioral interve	ntions, unless clinically		(3) months to ensure tha	
		an effort to discontinue these		the non-pharmacological	
1	drugs.			interventions have been	
				attempted prior to	
				medication administratio	n
				and that effectiveness of	
				intervention has been	
		ENT is not met as evidenced		documented.	
1	by:	terview, facility document		4. Results of the reviews	will
	review and clinic	al record review, it was		be discussed by the	
•	determined that fa	acility staff failed to ensure one		administrator/designee a	t
	of 16 residents w	as free from unnecessary		the Quality Assurance	•
	medications; Res	ident #309.		Performance Improvemen	nt
	The facility staff f	ailed to provide		meeting monthly for three	
	non-pharmacolog	gical interventions to Resident		(3) months and then	
	#309 prior to the	administration of prn (as		quarterly. The committee	S
	needed) Xanax (1) and failed to document if		will recommend provision	

The findings include:

7/31/16.

Xanax was effective on 7/29/16, 7/30/16 and

Resident #309 was admitted to the facility on 9/22/2009 with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease, Osteoarthritis, high blood pressure,

Facility ID: VA0008

to the plan as indicated to

sustain substantial

compliance.

5.8-22-16

MENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/16/2016 FORM APPROVED

DEPART	KENI OF HEALIN	& MEDICAID SERVICES					. 0938-0391
STATEMENT	OF OFFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l		NSTRLICTION	(X3) DAT	E SURVEY MPLETEO
ANO FLAN O	1 003((1201)0.)						₹-C
		495362	B. WING				/03/2016
NAME OF F	ROVIOER OR SUPPLIER				T AOORESS, CITY, STATE, ZIP C	00E	
	S AUDOING AND BE	UADII ITATION	İ		HOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		ASHL	_AND, VA 23005		
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFŸIÑĞ İNFÖRMATION)	IO PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE	(X5) COMPLETION DATE
رت ع ع ص <i>ا</i>	Cartinual From p	050 43	{F 3	(29)			
(F 329)			ارا د	,29			
	bipolar disorder, and schizophrenia, and disorder.	nxiety disorder, paranoid d narcissistic personality					
	Resident 309's mo	ost recent MDS (Minimum Dat	а				
	Set) was a quarter	rly assessment with an ARD					
	(assessment refer	ence date) of 5/27/16. s coded as being cognitively					
	Resident #309 wa	to make daily decisions scori	ng				
	15 out of 15 on the	e BIMS (Brief Interview for					
	Mental Status) ex	am. Resident #309 was code	d				
	as requiring super	vision with most ADLS					
	(Activities of Daily	Living).					
	Review of Reside	nt #309's POS (Physician Ord	ler				
	Sheet) dated 7/31	1/16, documented the following	g				
	order: "ALPRAZO)LAM 1MG (milligram) TABL⊟	T				
	(XANAX) Take 1	tab (tablet) by mouth every 8					
	hours as needed.	"					
	Raviow of Reside	nt #309's care plan document	ted				
	the following unde	er care area Behavior/Mood:					
Į	"Anti-anxiety: Nor	n-drug interventions-see					
	hehavior manage	ment care plan." Review of the	ne				
	behavior manage	ment care plan dated 5/26/15	l				
	documented the	following interventions:					
:	"Introduce self Wi	nen providing care, explain sident before providing care,					
	procedures to res	s for underlying medical cause	es,				
	assess resident f	for pain as indicated,				,	
	nsychological col	nsult as needed, medications	per				,
Ì	physician orders.	. Invite and assist as needed t	0				•
	activities of choic	e, encourage resident to atter	าต			•	
	group activities, l as needed"	Redirect inappropriate behavio	J: 5				
	Review of Reside	ent #309's July 2016 MAR	<u>۔</u>				
	(Medication Adm that Resident #3	inistration record) documente 09 received Xanax prn (as	ū				

FORM CMS-2567(02-99) Previous Versions Obsolele

Eveni IO: J2WF14

Facility IO: VA0008

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		((
DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/16/2016 APPROVED 0938-0391
STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILOING) COM	E SURVEY IPLETEO
		495362	B. WING			08/	03/2016
	ROVIDER OR SUPPLIER D NURSING AND RE	HABILITATION		™ 906 T	ET AOORESS, CITY, STATE, ZIP COOE THOMPSON STREET ILAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	IO PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECT [EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY]	LO BE	(X5) COMPLETION DATE
{F 329}	Continued From p	age 44 lowing dates and times:	{F 3	329)			
	7/28/16 at 10 a.m. 7/29/16 at 9 a.m. 7/30/16 at 9 a.m. 7/31/16 at 9 a.m. 7/31/16 at 9:50 p.						
	documentation the	sing notes revealed no at non-pharmacological e attempted prior to the Xanax on the above dates.					

On 7/29/16 through 7/31/16 there was no documentation as to why the Xanax was administered and if it was effective.

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding the process staff follow prior to administering prn (as needed) psychoactive medication. LPN #2 stated that he would try to re-direct the resident first and try non-pharmacological interventions before administering medication. He stated that he would document these interventions. LPN #2 stated, "I would document just so it didn't look like I was just medicating him." LPN #2 reviewed Resident #309's MARs and nursing notes and confirmed that he did not see non-pharmacological interventions attempted prior to administering the Xanax. LPN #2 also stated he did not see documentation as to why Xanax was administered on 7/29/16, 7/30/16 and 7/31/16. LPN #2 confirmed that there was no documentation that the Xanax had been effective.

On 8/3/16 at 11:00 a.m., an interview was conducted with LPN #4, regarding the process

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Facility IO: VA000B

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/16/2016 FORM APPROVED

DEPART	MENT OF FIEALTH	O MEDICAID SERVICES	OMB NO. 0938-039					
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
						ì	R-C	
		495362	B. WING		OTAL CASE TO CODE	08	3/03/2016	
NAME OF F	PROVIDER OR SUPPLIER			i	TREET ADDRESS, CITY, STATE, ZIP CODE 06 THOMPSON STREET			
ASHLAN	D NURSING AND RE	HABILITATION	;		ASHLAND, VA 23005			
AOTIEZAN					PROVIDER'S PLAN OF CORRECT	ION	[X5]	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE	
(E 220)	Continued From pa	age 45	⟨F 3	293				
[{r 329}	Continued From pa	administering prn (as needed)	γ, ο	~~;				
	psychoactive medi-	cation. LPN #4 stated that she						
	would attempt other	er things prior to administering			•			
	medications. LPN	#4 stated that she would offer and document that she						
	snacks, drinks etc.	armacological interventions.						
	I PN #4 stated she	could not find evidence that						
	non-pharmacologic	cal interventions were put into						
	place prior to the a	idministration of the Xanax. find evidence of documentation						
	LPN #4 could not i	dent #309 had received the						
	Xanax on 7/29/16.	7/30/16 and 7/31/16. LPN #4						
	stated "He doesn'	t usually get Xanax for me but I			•			
	heard that he asks	s for it." LPN #2 stated that we attempted to offer the						
	resident alternative	es to decrease his anxiety prior						
	to administering X	anax. LPN #4 also stated that						
	a note should be c	reated documenting attempts.						
	On 8/3/16 at 2:35	p.m., ASM #1, the Executive						
	Director, ASM #2,	the Director of Clinical						
	Services, ASM #3,	, the Assistant Director of						
	Clinical Services,	and ASM #4, the Regional						
	the above findings	Services were made aware of						
	The facility Policy	titled, "Psychoactive						
	Medications" docu	ments in part, the following:						
	/, Non-Pharma	cological Interventions will be g psycho-pharmacological						
]	drugs to the exten	t possible."						
	-							
	According to Fund	damentals of Nursing, 5th						

Wilkins, page 565, "Nurses also are responsible for documenting the therapeutic effects and side

(1) Xanax- used to relief symptoms of anxiety

effects of any medication administered."

DEPARTMENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 08/1 FORM APPE OMB NO. 0938	ROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCT		(X3) DATE SUR COMPLETE	VEY
	495362	B. WING			R-C 08/03/20	016
NAME OF PROVIDER OR SUPPLIER	LIABILITATION		906 THOMPSO		DDE	
ASHLAND NURSING AND RE			ASHLAND, V	A 23005 OVIDER'S PLAN OF COR	PECTION	195)
JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC)	OVIDERS PLAN OF COR H CORRECTIVE ACTION -REFERENCED TO THE A DEFICIENCY)	SHOULD BE COL	(X5) MPLETION DATE
used to treat panion This information we lostitutes of Health	aused by depression. It is also disorder in some patients. as obtained from The National	. •	329}		·	
0008896/?report=	m.nih.gov/pubmedhealth/PMHT details. PLETE/ACCURATE/ACCESSIE	{F	514}			
resident in accord	maintain clinical records on each lance with accepted professions actices that are complete; nented; readily accessible; and ganized.	h al		F 514		
information to ide resident's assess services provided	d must contain sufficient entify the resident; a record of the ments; the plan of care and d; the results of any reening conducted by the State; es.			1. Resident #30 medications as order. Resident documented passessment as porder. Resident abdominal bind	per Physician t #314 has a ain per Physician t #316 has	
by: Based on staff in and facility document that the facility stand accurate cling residents in the stand # 314, and # 316				and a skin chec completed as o 2. Residents the the facility have potential to be failure to docum completion of nadministration,	k has been rdered. at reside in e the affected by ment nedication	
1. For Resident document that n	# 307 the facility staff failed to nedications were administered o	on			haiii	

FORM CMS-2567(02-99) Previous Versions Obsolele

7/29/16 at 5:00 p.m.

2. The facility staff failed to document pain

Event ID: J2WF14

Facility ID: VA0008

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/16/2016 FORM APPROVED

OFFICE FOR MEDICAL	RE & MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	SURVEY PLETED
AND PLAN OF COTALESTIC.	495362	B. WING				-C
		D: 11110		ET ADDRESS, CITY, STATE, ZIP CODE	 _	03/2016
NAME OF PROVIDER OR SUPPLI	ER		1	HOMPSON STREET		
ASHLAND NURSING AND	REHABILITATION		1	_ANĎ, VA 23005		
(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) CDMPLETIDN DATE-
{F 514} Continued From	page 47	•	514}	assessments, skin o	checks	
assessment tha	t was ordered by the physician or	n '		and placement of a		
several occasio	ns in July of 2016 for Resident #			binders.	.paomina	
314.				3. Licensed Nursing	staff has	
	aff failed to document that an			been educated on	=	
3. The facility st	er was in place and skin checks			Physician orders fo	_	
were provided (on 7/29/16 and 8/1/16 for Resider	nt		medication admini		
# 316.				following treatmer	-	
				and accurate and o		
The findings in	sludo:			documentation. Lie	•	
The findings inc	dude.			Nursing staff has a		
1. Resident #3	307 was admitted to the facility or	1		completed a medic		
10/26/12 and re	eadmitted on 1/23/13 with			administration cou		
diagnoses that	included but were not limited to:			MARs/TARs will be		
anemia, hypert	ension, hyperlipidemia, seizure tes, depression, chronic			daily x3 months th		
gisorder, diabe	monary disease, abdominal aortic	5		x 3 months by DCS	*	
aneurysm, atria	al fibrillation, and glaucoma.			to ensure that med	-	
				are being administ		
The most rece	nt MDS (minimum data set)	אר		per Physician orde		
assessment, a	quarterly assessment with an AF eference date) of 6/9/16 coded	(D		treatments have b		
Resident # 307	as usually understood by others	i		executed as per Ph		•
and usually ab	le to understand others. Residen	nt		order, to include a	•	
# 307 was cod	ed as scoring 7 out 15 on the Brid	ef		binders and skin cl		
Interview for M	lental Status in Section C,			biliders and skill ci	IECK2	
Cognitive Patti cognitively imp	erns, indicating the resident was aired.					
Review of the orders for the	clinical record revealed physician following:	-				
recently signe	dered dated 1/17/14 and most d by the physician on 7/30/16: ENE GLYCOLFOR MIRALAX ((1)				

FORM CMS-2567(02-99) Previous Versions Obsolete

MIX 17 GM (grams) (1 CAPFUL) IN 8OZ (ounces) OF WATER OR JUICE AND TAKE BY MOUTH TWICE DAILY (9AM & 5 PM) (9:00 a.m.

EvenI ID: J2WF14

Facility ID: VA0008

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391

STAT	EMENT	OF!	DEFIC	IENCIES
NID	DIAIJ O	E CC	RREC	TION

(X4) ID

PREFIX:

TAG

(X1) PROVIDER/SUPPLIER/CLIA

495362

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

B. WING

R-C 08/03/2016

NAME OF PROVIDER OR SUPPLIER

ASHLAND NURSING AND REHABILITATION

STREET AODRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005

> (X5) COMPLETION OATE

{F 514} Continued From page 48 & 5:00 p.m.)."

{F 514}

ID

PREFIX

TAG

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "SENOKOT (2)...2 TABLETS BY MOUTH TWICE DAILY (9AM & 5PM)."

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "SODIUM BICARBONATE (3) 650 MG (milligrams) TABLET 1 TAB (tablet) BY MOUTH TWICE DAILY (9AM & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "GABAPENTIN (4) 300 MG 1 CAP (capsule) BY MOUTH THREE TIMES DAILY (9AM, 1PM, & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "MEXILETINE HCL (5) 150 MG CAPSULE 1 CAP BY MOUTH THREE TIMES DAILY (9AM, 1PM, & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "MIDODRINE HCL (6) 5 MG TABLET 1 TAB BY MOUTH THREE TIMES DAILY (9AM, 1PM, & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "LEVETIRACETAM (7) 500 MG TABLET...1 TAB (tablet) BY MOUTH TWICE DAILY (9AM & 5PM)."

Review of the MAR (medication administration record) for 7/29/16 at 5:00 p.m. revealed that

4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.
5. 8-22-16

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

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EvenI ID: J2WF14

Facility ID: VA0008

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					. 0938-0391
		& MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA	(X2) MIII	TIPLE C	ONSTRUCTION	(X3) OAT	E SURVEY
STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1			COMPLE R-C		
		495362	B. WING	i		l l	/-C /03/2016
MANUE OF C	PROVIOER OR SUPPLIER			STRE	EET ADORESS, CITY, STATE, ZIP COOE		
				1	THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		ASH	HLAND, VA 23005		
(X4) IO - PREFIX- TAG	TACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREF TAC	-IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULŐ BE	(X5) COMPLETION OATE
			l⊏ i	514}			
{F 514}	Continued From p	age 49	γ ι .) 1 -1 }			
<u> </u> 	there was no docu medications were	mentation that the above administered.					
	I DNI /licensed nra	w on 8/3/16 at 9:20 a.m. with actical nurse) # 1 when asked the MAR, LPN # 1 stated that					
	blanks mean that	staff did not sign out the signing out looks like the ot given but does not mean tha	t				
	LPN # 2, LPN # 2 there is a blank o either means the not give the medi probably just forg		u				
	LPN # 4, LPN # 4 MAR mean. LPN taught that if it is	ew on 8/3/16 at 10:50 a.m. with 4 was asked what blanks on the N # 4 stated that in school we a not documented then it is not an miss signing off and one worthe individual nurse was asked	re uld				
	LPN # 5, LPN # MAR mean. LP	iew on 8/3/16 at 11:17 a.m. with 5 was asked what blanks on th N # 5 stated that a blank mean it tould mean they (nurse) just that the medication was give	s it st				
	a.m. with LPN # # 307 on 7/29/1	s conducted on 8/3/16 at 11:45 10 the LPN assigned to Reside 6 and who was responsible for the Resident's medications. LPN tow I gave the medications, I do	1#				

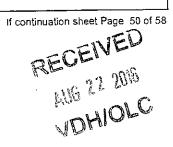
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know why I didn't sign them off but I did give them. I may have gotten distracted by another

resident, but I know I gave them."

Event IO: J2WF14

Facility IO: VA0008



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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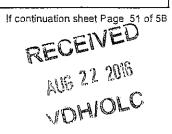
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0.0938-0391	
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONS				TE SURVEY MPLETEO
							R-C
		495362	B. WING			9.0	3/03/2016
NAME OF I	PROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE		
ASHLAN	ID NURSING AND RE	HABILITATION		ļ.	THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	IX	PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	DULO BE	(X5) COMPLETION DATE
{F 514}	Continued From pa	age 50	{F	514}			
	ASM (administrative executive director, clinical services, and director of clinical)	v on 8/3/16 at 2:25 p.m. with ve staff member) # 1, the ASM # 2, the director of nd ASM # 3, the regional services, this concern was v of the facility policy was					
	Records" under "P maintained in acco practice standards	ity policy: "Clinical/Medical colicy:Clinical Records are cordance with professional sto provide complete and on on each resident for"					
	No further informa	tion was provided prior to exit.					
	Incredibly Easy, Li Philadelphia PA, p documentation is a documentation is a nursing care. Patie and need to be act that care can be of health care team. documentation pro- patient and family possible. Many nu- they document or enormous effect of	damentals of Nursing Made ippincott Williams and Wilkins, page 23: "Nursing a highly significant issue since a fundamental feature of ent records are legally valid, ecurate and comprehensive so communicated effectively to the Unless the content of ovides an accurate depiction of care, quality of care may not burses do not realize that what fail to record can produce an on the care that is provided by the health care team."	:				
	(1) MIRALAX (Pol treat occasional c	lyethylene glycol) is used to constipation. Polyethylene glyco	I				

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is in a class of medications called osmotic laxatives. It works by causing water to be retained

Event ID: J2WF14

Facility ID: VA0008



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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& MEDICAID SERVICES		OMB NO. 0938-0391			
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
495362	B. WING		R-C 08/03/2016		
		STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005			
Y MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COR	SHOULD BE COMPLET		
s increases the number of and softens the stool so it is s.gov/druginfo/meds/a603032. enna) is used on a short-term stipation. It also is used to before surgery and certain es. Senna is in a class of d stimulant laxatives. It works to of the intestines to cause a s.gov/druginfo/meds/a601112. ARBONATE is an antacid used an and acid indigestion. Your or scribe sodium bicarbonate to urine less acidic in certain us.gov/druginfo/meds/a682001 N capsules, tablets, and oral to help control certain types of e who have epilepsy. The burning, stabbing pain or east for months or years after an an acid to treat restless legs a condition that causes legs and a strong urge to move appentin is in a class of	h py ht o h f s re				
	### AP5362 #### AP5362 ##### AP5362 ##### AP5362 ##### AP5362 ##### AP5362 ###### AP5362 ###### AP5362 ###### AP5362 ########### ############ ##########	(X2) MULA BUILD 495362 B. WING CHABILITATION ATEMENT OF DEFICIENCIES PROBLES OF MUST. BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) AGE STANDARD OF TH	(X1) PROVIDERSUPPLIERCULA (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u> NNR NO</u>	. 0938-0391
STAT EMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION		E SURVEY IPLETED
		495362	B. WING			1	R-C / 03/2016
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
ASHLAN	D NURSING AND RE	HABILITATION	<u>[</u>		STHOMPSON STREET SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
(F 514)	pain of PHN by ch senses pain. It is r gabapentin works https://medlineplus tml (5) MEXILETINE i ventricular arrhyth Mexiletine is in a co	orain. Gabapentin relieves the anging the way the body not known exactly how to treat restless legs syndrome. s.gov/druginfo/meds/a694007.h s used to treat certain types of mias (abnormal heart rhythms). class of medications called		14}			
	electrical signals in rhythm. https://medlineplutml (6) MIDODRINE responsible to the first that	works by blocking certain in the heart to stabilize the heart s.gov/druginfo/meds/a607064.h may cause supine hypertension ure that occurs when lying flat is medication should only be hose low blood pressure are ability to perform daily occuld not be treated other therapies. Tell your doctor we ever had high blood pressure and pharmacist if you are taking to (DHE, Migranal). Also tell you nacist what other prescription on medications you are taking, ne, phenylephrine, mine, and pseudoephedrine.					
	Many nonprescripmedications (e.g. cough and colds) experience any otaking midodrine immediately: awa	otion products contain these diet pills and medications for so check labels carefully. If yo f the following symptoms, stop and call your doctor areness of your heartbeat, ears, headache, or blurred	u				

https://medlineplus.gov/druginfo/meds/a616030.h

vision.

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PRINTED: 08/16/2016

		AND HUMAN SERVICES					. 0938-0391
		& MEDICAID SERVICES	(73/1/41/13		CONSTRUCTION		. 0936-039 [TE SURVEY
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COI	MPLETED
		495362	B. WING			\	/03/2016
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	n MUDOINO AND DE	LADILITATION		90	6 THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION	}		SHLAND, VA 23005		
(X4) IO SUMMARY STATEMENT OF OEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IOENTIFYING INFORMATION)			ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	IX5) COMPLETION OATE
{F 514}	Continued From page	age 53	{F 5	14}			
	tml						
	called anticonvulsa	TAM in a class of medications ants. It works by decreasing ent in the brain. s.gov/druginfo/meds/a699059.h					
	assessment that v	failed to document pain vas ordered by the physician or in July of 2016 for Resident	1		•		
	4/17/15 with diagral limited to osteoard chronic pain synd Alzheimer's disea Resident #314's rate Data Set) was a control of ARD (Assessment Resident #314 was impaired in cognitate BIMS (Brief Intexam. Resident supervision with rate Living) and exten Review of Reside (Physician Order following order: "I (0-10) chart even by the physician of Review of Reside revealed no signal."	is admitted to the facility on moses that included but were no thritis, diabetes mellitus type 2, rome, high blood pressure, se, and unspecified dementia. In ost recent MDS (Minimum quarterly assessment with an at Reference Date) of 7/1/16. It is coded as being severely tion, scoring three out of 15 on atterview for Mental Status) if 314 was coded as requiring most ADLS (Activities of Daily sive assistance with bathing. In #314's July 2016 POS Sheet) documented the ndicate Pain Status/Rating: y shift." This order was signed on 7/19/16. In the #314's July 2016 MAR atures documented on the nd shifts for pain monitoring:	t				

7/31/16 11-7 shift FORM CMS-2S67(02-99) Previous Versions Obsolete

7/29/16 11-7 shift 7/30/16 3-11 shift 7/30/16 11-7 shift

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Facility ID: VA0008

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		& MEDICAID SERVICES					. 0938-0391	
STATEMENT	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			ONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. • •	495362	B. WING				R-C /03/2016	
NALÆ OF I	PROVIOER OR SUPPLIER	433002			EET AOORESS, CITY, STATE, ZIP COOE		100/2010	
				906	THOMPSON STREET			
ASHLAN	D NURSING AND RE	HABILITATION		ASH	ILAND, VA 23005			
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{F 514}	notes for the above documentation of On 8/3/16 at 10:13 conducted with LF #2. When asked meant on the MAF assessment was a shift forgot to sign assessment, the reducement because every shift when worder on 8/3/16 at 10:3 conducted with LF blanks meant on either the medica or the nurse forgonurses can some When asked how prior to her compadministered a mean we are supposed the oncoming nursure there are no On 8/3/16 at 2:35 Director, ASM #2 Services, ASM #Clinical Services, Director of Clinical Services, Director of Clinical the above finding Facility Policy title documented the maintained in accurate information of care continuity of care continuity of care continuity of care continuity of care continuity of care continuity of care continuity of care continuity of care continuity of care continuity of care continuity of care care care care care care care care	at #314's July 2016 nursing to dates revealed no a pain assessment. As a.m., an interview was PN (Licensed Practical Nurse) what blanks (No signatures) PN, LPN #2 stated either the pain to completed or the nurse on LPN #2 stated, "With the pain to see the resident." With the pain to see the resident." Sa.m., an interview was PN #4. When asked what the MAR, LPN #4 stated that the most of the sign. LPN #4 stated that times miss documenting. If she would know if the nurse leted a certain task or edication, LPN #4 stated, "We to check over the MARS with the check over the MARS with the professional as Services were made aware of the provide complete and the provide c	n n	514}				

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The following quotation is found in Potter and

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Facility IO: VA0008

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PRINTED: 08/16/2016

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			FORM	APPROVED . 0938-0391		
CENTERS FOR MEDICARE STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION	X1) PROVIOER/SUPPLIER/CLIA (X2)		TIPLE CONSTRUCTION NG	, cor	(X3) OATE SURVEY COMPLETEO R-C		
	495362	B. WING		1	/03/ 2 016		
NAME OF PROVIOER OR SUPPLIER		1	STREET AOORESS, CITY, STATE, ZIP CODE				
	JADII ITATION	1	906 THOMPSON STREET				
ASHLAND NURSING AND RE		<u>_</u>	ASHLAND, VA 23005				
(A4) IO (ENC)	ITEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		DULO BE	(X5) CDMPLETION DATE		
(F 514) Continued From pa	age 55	{F 5	14}				
F 514} Continued From page 55 Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." 3. Facility staff failed to document that an abdominal binder was in place and skin checks were provided on 7/29/16 and 8/1/16 for Resider #316. Resident # 316 was admitted to the facility on 6/8/16 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), muscle weakness, heart failure, high blood pressure and chronic respiratory failure. Resident #316's most recent MDS (Minimum Data Set) was a five day scheduled assessmen with an ARD (Assessment Reference Date) of 7/29/16. Resident #316's was coded as being severely cognitively impaired in the ability to madaily decisions scoring three on the staff assessment for mental status exam. Resident		nt t t					

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needed)..."

#316 was coded as requiring extensive

coded as having a peg tube.

assistance to being dependent on staff with ADLS (Activities of Daily Living). The resident was

On 7/22/16 the following physician order was documented, "Abdominal Binder check placement and skin qs (every shift) and prn (as

Review of the July 2016 MAR revealed that on July 29th, 30th, and 31st 2016, the MAR was left

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Facility ID: VA0008

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PRINTED: 08/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING_ AND PLAN DF CORRECTION R-C 08/03/2016 B. WING 495362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 906 THOMPSON STREET ASHLAND NURSING AND REHABILITATION ASHLAND, VA 23005 PROVIDER'S PLAN OF CORRECTION [X5] SUMMARY STATEMENT OF DEFICIENCIES ID. COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {F 514} {F 514} Continued From page 56 blank for 7-3, 3-11 and 11-7 shift for the Abdominal binder order. On August 1st, for 11-7 and 7-3 shift, the MAR was left blank for the Abdominal Binder order. On 8/3/16 at 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked what blanks meant on the MAR, LPN #4 stated that either the medication or task was not completed or the nurse forgot to sign. LPN #4 stated that nurses can sometimes miss documenting. When asked how she would know if the nurse prior to her completed a certain task or administered a medication, LPN #4 stated, "Well we are supposed to check over the MARS with the oncoming nurse at change of shift to make sure there are no holes (blanks) in the MAR." On 8/3/16 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7, the nurse who worked the weekend on July 30th through the 31st 2016. When asked what blanks meant on the MAR she stated the nurse may have forgotten to sign the MAR or the treatment or medication was not administered. LPN #7 stated that she had worked on 7/30 and 7/31 7-3 and 3-11 shift. When asked if she had Resident #316, she stated that she did. When asked if he had his abdominal binder in place she stated that she was not sure about Saturday but she knew on Sunday he did not have one in place. When asked why he did not have his

abdominal binder in place, LPN #7 stated, "I didn't think we were putting it on him because he had a peg tube infection." When asked if she had documented anywhere that she did not place the binder on due to an infection, LPN #7 stated that

	DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/16/2016 APPROVED 0938-0391
-	TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, '		CONSTRUCTION	COM	E SURVEY PLETED
			495362	B. WING			1	03/2016
_	NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
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	{F 514}	hold the abdomina	n asked if there was an order to al binder until the infection ated that she could not vas not one of the nurses who	{F 5	514}			
		conducted with LF	0 a.m., an interview was PN #8. She stated that had t 1st pn 11-7 shift. She stated al binder was in place during he	er				
	l l	The other nurses interview.	could not be reached for an					
		Director, ASM #2 Services, ASM #	5 p.m., ASM #1, the Executive 2, the Director of Clinical 3, the Assistant Director of , and ASM #4, the Regional al Services were made aware o	of				
		No further inform	nation was presented prior to ex	kit.				

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